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In The

Supreme Court of the United States

October Term, 1993

MARY KUHL, BUDDY KUHL, JR. AND MARNIE K. KUHL,

Petitioners,

v.

LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC.,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the court of appeals correctly decided that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, preempts state law claims, including tort claims, against an ERISA plan administrator?

2. Whether the district court and court of appeals properly considered Lincoln National's motion for summary judgment by reviewing the facts in the light most favorable to petitioners?

LIST OF PARTIES

Petitioner Mary Kuhl

Petitioner Buddy Kuhl, Jr.

Petitioner Marnie K. Kuhl

Respondent Lincoln National Health Plan of Kansas City, Inc.*

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*The following corporations are related to Lincoln National Health Plan of Kansas City, Inc.: Lincoln National Corporation; TakeCare, Inc; TakeCare Administrative Services Corporation; The Medical Protective Company; Lexington Insurance Company; Kansas Health Care Stabilization Fund; Kansas Medical Mutual Insurance Company, on behalf of The Kansas Health Care Provider Insurance Availability Plan; Reliance National Insurance Company; National Union Fire Insurance Company; American States Insurance Company; Chubb Group of Insurance Companies.

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BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

This case involves claims made with respect to the death of a participant in an ERISA-covered group health plan. Respondent Lincoln National Health Plan of Kansas City, Inc. ("Lincoln National") was the plan administrator. All relevant actions of Lincoln National were taken in the course of determining whether benefits were payable under the plan. Petitioners' claims therefore are preempted, and their arguments to the contrary defy this Court's well-established precedent, which has been applied as recently as last year to deny certiorari in a case strikingly similar to this case. Accordingly, Lincoln National respectfully requests that this Petition for Writ of Certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit be denied.

STATUTES AND RULES INVOLVED

This case involves the application of the preemptive effect of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.*, particularly § 514(a), 29 U.S.C. § 1144(a).

STATEMENT OF THE CASE

A. *Factual Background.*

There is no dispute as to any of the facts material to the district court's grant of summary judgment, and the affirmance of that ruling by the Eighth Circuit Court of Appeals.[1] Buddy Kuhl was an employee of Belger Cartage Services, Inc. ("Belger"), and was a participant in the

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[1] Lincoln National takes issue with many of the factual characterizations made by petitioners. However, because

Belger Group Medical Plan ("Belger Plan"), a group medical plan sponsored by Belger. Lincoln National was the administrator of the Belger Plan, which is both an "employee benefit plan" and an "employee welfare benefit plan" within the meaning of ERISA. As the court of appeals noted, "Lincoln National Health Plan is an 'independent physician' HMO, which means that it pays independent physicians, hospitals, and other health care providers to render medical services for its members." *See* Petitioners' Appendix ("P.App.") at A-2. Mr. Kuhl never was examined or treated by any physician or nurse employed by Lincoln National, and Lincoln National never rendered medical services to Mr. Kuhl. Lincoln National's responsibilities were limited to decisions respecting the payment of claims or benefits under the Belger Plan.

Mr. Kuhl, as a Belger employee, and his dependents, Mary and Marnie Kuhl, agreed to the terms of and became members in the Belger Plan. Pursuant to the contract between Lincoln National and Belger, Lincoln National paid for medical services provided to Belger employees according to the restrictions, limitations and exclusions of the Belger Plan. As the court of appeals highlighted, "Lincoln National is not contractually obligated to pay for medical services rendered outside the 'Service Area' of the Lincoln National network or for medical services rendered by personnel not participating in the Lincoln National network." P.App. at C-2. The principal document governing the Belger Plan provided:

> "Service Area" is the geographical area within which HMO's covered services are available.

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petitioners cannot dispute any fact material to ERISA's preemptive scope, the extraneous factual allegations made by petitioners will not be addressed here.

> This includes the counties of Jackson, Clay, Platte, Cass, Buchanan, Ray and LaFayette in Missouri and Johnson and Wyandotte in Kansas. The Service Area may be revised by HMO as HMO deems necessary.
>
> * * *
>
> Except for Emergency Services as provided in Section L,[2] these services and benefits are available only in the Service Area and only if, and to the extent that, they are provided, prescribed, or directed by a Plan Physician in accordance with the terms of the Group Medical and Hospital Service Certificate.

The district court ruled that "Lincoln National is not obligated to automatically pay for medical services rendered outside the 'Service Area' of the Lincoln National network." P.App. at C-2.

Lincoln National became involved with considering whether payment would be authorized under the Belger Plan for Mr. Kuhl's proposed surgery at Barnes Hospital ("Barnes") of St. Louis, Missouri in June, 1989. At that time, Barnes contacted Lincoln National to verify that the Belger Plan would pay for Mr. Kuhl's surgery scheduled to take place on July 3, 1989. Lincoln National did not initially certify benefits for the surgery because Barnes was outside the Lincoln National "Service Area" as defined by the Belger Plan.[3] Lincoln National, after further consideration of Mr. Kuhl's precertification request,

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[2] The "Emergency Services" exception, as defined in the Belger Plan, did not apply in this case.

[3] Lincoln National offered a PPO ("preferred provider program") option under the Belger Plan, which provided benefits regardless of whether a doctor or institution was a "preferred provider", although the amount of the benefit was less if a plan member chose a non-preferred provider. Mr. Kuhl did not choose the PPO option, instead choosing Lincoln National's

authorized payment of benefits for the non-"Service Area" surgery, but the surgery was not performed and Mr. Kuhl died while awaiting a heart transplant. Presumably the physicians who in fact were caring for Mr. Kuhl throughout this time period did not believe there was a risk in the delay. Petitioners have not made any claims against these parties.

As stated by the district court, "Lincoln National conducts a precertification review of hospital admissions. In the precertification review, Lincoln National determines whether a particular provider or hospitalization is covered by the Plan." P.App. at C-3. The precertification procedure under which Mr. Kuhl's surgery allegedly was "cancelled" was a condition precedent to the payment of benefits under the Belger Plan, and Lincoln National's precertification process was a claims administrative function under the Belger Plan. Lincoln National made such decisions by reviewing coverage for benefits and determining whether a particular procedure or hospitalization met the requirements of Lincoln National's contract with the employer and participant.

These facts, although ignored almost entirely by petitioners in their attempt to characterize Lincoln National's administrative actions as "medical malpractice", are the only facts material to the dispositive issue in this case – ERISA preemption. Petitioners have not disputed any of these material facts.

HMO option which provides a higher benefit percentage, but *only* for certain physicians and institutions within the Belger Plan's "Service Area."

B. *Proceedings In The Lower Courts.*

Petitioners originally filed suit against Lincoln National in the Circuit Court of Jackson County, Missouri, alleging four causes of action: (1) medical malpractice; (2) tortious interference with contractual relations; (3) intentional infliction of emotional distress; and (4) breach of contract.[4] Petitioners did not allege that any of their claims were made under ERISA.

Lincoln National removed the case to federal court pursuant to 28 U.S.C. § 1441(b) and ERISA's "complete preemption doctrine." Petitioners sought remand, arguing ERISA preemption did not apply. Lincoln National opposed petitioners' motion to remand, and subsequently moved for summary judgment on the grounds of ERISA preemption.

1. *The District Court's Order In Kuhl I.*

In an order dated December 26, 1991, the district court granted Lincoln National's summary judgment motion and denied petitioners' motion to remand. Specifically, the district court ruled that ERISA preempts petitioners' alleged causes of action:

> Plaintiffs in this case do not make a direct claim for contractual benefits under the Group Medical Plan. However, plaintiffs are asserting claims that *arise from the administration of that Plan*. . . .

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[4] As set forth below, petitioners filed two separate lawsuits against Lincoln National. The first suit was captioned *Mary Kuhl, Marnie Kuhl, and Buddy Kuhl, Jr. v. Lincoln National Health Plan of Kansas City, Inc.*, Case No. 91-0330-CV-W-9, and will be referred to hereafter as "Kuhl I". Petitioners also filed a second suit captioned *Mary Kuhl, Marnie Kuhl and Buddy Kuhl, Jr., v. Lincoln National Health Plan of Kansas City, Inc.*, Case No. 91-1146-CV-W-9, which will be referred to hereafter as *"Kuhl II"*.

> According to the normal meaning of the statutory words "relate to", each of plaintiffs' claims "has a connection with" the Plan or, more specifically, each claim "arises from the administration of the Plan." Plaintiffs' claims are based on the manner in which Lincoln National responded to the request for "Pre-certification" of Buddy Kuhl's heart surgery.

P.App. at C-15, 16 (emphasis in original). The district court then concluded:

> Artful pleading by characterizing Lincoln National's actions in refusing to pay for the surgery as "cancellation" or by characterizing the same administrative decisions as "malpractice" does not change the fact that plaintiffs' claims are based on the contention that Lincoln National improperly processed Kuhl's claims for medical benefits. Thus, plaintiffs' claim "relate to" the Plan and are preempted by § 514(a).

P.App. at C-16, 17. Finally, even though petitioners made no attempt to allege a cause of action under ERISA, the district court reviewed the complaint to determine if petitioners could properly state an ERISA-based claim. After discussing every potential subsection under which petitioners even arguably could allege an ERISA-based cause of action, the court determined no ERISA claim existed. P.App. at C-21.[5]

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[5] Petitioners make no claim to this Court that the district court or the court of appeals erred in determining that 29 U.S.C. § 1132(a)(3) does not provide for "extra-contractual relief," and do not seek certiorari to address this issue. Indeed, this Court's recent decision in *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063 (1993), establishes that the rulings by the courts below were correct.

2. *Petitioners File Suit In Kuhl II.*

On December 27, 1991, one day after the Court issued its order in *Kuhl I*, petitioners filed suit in *Kuhl II* based upon facts and circumstances identical to those in *Kuhl I*. Petitioners alleged in their *Kuhl II* complaint that Lincoln National breached a fiduciary duty under ERISA.

Lincoln National moved to dismiss petitioners' complaint because, alternatively: (1) res judicata barred petitioners' claims; (2) petitioners had no cause of action under ERISA for any alleged breach of fiduciary duty; and (3) ERISA does not provide for extracontractual damages under 29 U.S.C. § 1132(a)(3).

3. *Petitioners Move To Amend Their Complaint In Kuhl I.*

After the district court dismissed the case in *Kuhl I* and entered judgment on Lincoln National's behalf, petitioners moved to amend their *Kuhl I* complaint. The "amended" complaint in *Kuhl I* was identical to the complaint filed by petitioners in *Kuhl II*, alleging a cause of action under ERISA.

4. *The District Court Denies Petitioners' Motion To Amend In Kuhl I And Dismisses Petitioners' Complaint In Kuhl II.*

Even after dismissing the *Kuhl I* complaint, the district court held oral argument to consider, among other issues: (1) petitioners' motion that the court reconsider its grant of summary judgment in *Kuhl I*; (2) petitioners' motion to amend in *Kuhl I*; (3) petitioners' claim that the district court should have "recharacterized" their state law claims in *Kuhl I* as claims under ERISA; and (4) Lincoln National's motion to dismiss in *Kuhl II*. At the conclusion of oral argument, the district court thoroughly

reviewed each issue and entered judgment from the bench. In addressing petitioners' argument regarding the scope of ERISA's preemptive force during oral argument, the district court stated:

> It makes no difference whether defendant cancelled the surgery or caused it to be cancelled by not agreeing to pay for it or by rescinding the previous certification or agreement it would pay for it. However one characterizes what happened, the end result is that whatever Lincoln National did it did in response to and as part of the procedures under the plan that were required before payment could be expected by the plan for the surgical procedure that was being contemplated. In fact, it was my belief that no matter how one characterizes the facts advanced by the plaintiffs, the facts involve the allegation or contention that defendant improperly processed a claim for benefits by doing things that it shouldn't have done, and/or not doing things it should have done. In any event, these actions were done by the administrator of the plan in response to a request for a claim for benefits.

The district court went on to deny petitioners' motion to amend in *Kuhl I*. Additionally, the court granted Lincoln National's motion to dismiss the *Kuhl II* complaint on three grounds: (1) the final judgment in *Kuhl I* was res judicata as to petitioners' complaint in *Kuhl II*; (2) applying the same reasoning that warranted summary judgment in *Kuhl I*, petitioners could state no claim under ERISA for breach of fiduciary duty; and (3) the "the other equitable relief" clause in 29 U.S.C. § 1132(a)(3) does not include monetary damages.

5. *The Eighth Circuit's Ruling.*

The Eighth Circuit Court of Appeals affirmed the district court's judgments in favor of Lincoln National.

Upon careful review of the facts, the Eighth Circuit held that petitioners' claims were preempted because all actions taken by Lincoln National were performed in its role as an ERISA plan administrator:

> Taking the facts in the light most favorable to the Kuhls, as we must for purposes of Lincoln National's motion for summary judgment, we are compelled to agree with the district court. Lincoln National became involved in the cancellation of the St. Louis surgery only after the Barnes Hospital staff requested a precertification review. Lincoln National's admission that it "cancelled" the surgery cannot be stretched to imply that Lincoln National went beyond the administration of benefits and undertook to provide Buddy Kuhl with medical advice. Although the surgery in St. Louis was unquestionably cancelled as a result of Lincoln National's decision not to precertify payment, the decision not to precertify payment relates directly to Lincoln National's administration of benefits.

P.App. at A-11. The Eighth Circuit also ruled that ERISA preempts petitioner Mary Kuhl's claim for intentional infliction of emotional distress, *citing Johnson v. District 2 Marine Eng'rs Beneficial Ass'n*, 857 F.2d 514 (9th Cir. 1988) and *Powell v. Chesapeake and Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). Finally, relying upon this Court's decision in *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063 (1993), the Eighth Circuit ruled that monetary damages are not available under section 1132(a)(3). The pending petition for certiorari followed.

REASONS FOR DENYING THE WRIT

The dispositive issue in this case has been addressed by this Court on several prior occasions: does ERISA preempt a state law cause of action against an ERISA plan

administrator for alleged improper processing of a claim for benefits? Because the answer to this question is affirmative, and because none of the facts material to the application of ERISA's preemptive scope are disputed, the findings of preemption by both the district court and court of appeals are correct as a matter of law.

Moreover, petitioners have not demonstrated any special or important reason why this Court should grant their petition. Petitioners fail to present any decisions of this Court or any other circuit court of appeals that conflict with the decision below. Rather, the decisions of both lower courts are consistent with established precedent from this Court and other federal appellate courts. Relying primarily on a series of cases decided by this Court, numerous courts uniformly have held that state law claims of the nature alleged in this case are preempted. Further, this Court recently denied certiorari in a case with issues similar, if not identical, to those present here. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992).

Petitioners also claim, without merit, that the lower courts incorrectly applied the legal standard applicable to motions for summary judgment. An examination of the opinion below demonstrates that in evaluating Lincoln National's motion, the court of appeals properly viewed all material facts in the light most favorable to petitioners, and that there is no dispute as to any fact material to ERISA's application.

I. THE COURT OF APPEALS PROPERLY FOLLOWED THIS COURT'S PRIOR DECISIONS INTERPRETING ERISA'S PREEMPTIVE SCOPE.

The decision of the court of appeals is legally correct and consistent with prior decisions by this Court and those of other circuit courts.

Petitioners try to deflect attention from Lincoln National's administration of the Belger Plan by emphasizing alleged facts which are irrelevant to the issue of whether ERISA preempts the state law claims. Petitioners cite cases which are legally and factually insufficient to support their petition. All Lincoln National's actions were taken in relation to the administration of the Belger Plan and, therefore, ERISA preempts petitioners' alleged causes of action.

A. Substantial Precedent From This Court And Other Circuit Courts Supports The Court Of Appeals' Decision.

This Court has directly addressed the application of ERISA's preemptive scope. *E.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). In *Shaw*, the Court ruled that New York laws forbidding discrimination in employee benefit plans on the basis of pregnancy, and a law requiring employers to pay sick-leave benefits to employees unable to work because of pregnancy, were preempted by ERISA. This Court noted that "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. Critically, the Court ruled that Congress used the "relate to" language in 29 U.S.C. § 1144(a) in its broad sense:

> to preempt only state laws specifically designed to effect employee benefit plans would be to ignore the remainder of § 514(a). It would have been unnecessary to exempt generally applicable state criminal statutes from preemption from § 514(a), for example, if § 514(a) applied only to state laws dealing specifically with ERISA plans.

Id.

It was further observed in *Shaw*, based on ERISA's legislative history, that the preemption clause was not

limited to matters specifically covered by ERISA, such as reporting, fiduciary responsibilities and the like. *Id.* at 98. ERISA preempts state laws that relate to employee benefit plans regardless of whether they directly conflict with substantive provisions of an ERISA plan. *Id.* By giving the "relate to" phrase in § 514(a) its "broad, common-sense meaning," *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985), it is clear that state law claims, including those in this case, are intended to be preempted within the parameters of section 514.[6] This Court has "repeatedly stated that a law 'relates to' a covered employee benefit plan for purposes of § 514(a) 'if it has a connection with or reference to such a plan.' " *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992) (quoting *Shaw*, 463 U.S. at 97 (1983)); *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987).

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[6] Indeed, the breadth of the preemptive effect of ERISA is evidenced by Congress' refusal to enact proposed legislation which would have allowed preemption only of state laws specifically dealing with employee benefit plans. *See Shaw*, 463 U.S. at 98-99, nn. 18, 19 and 20; *Champion Int'l Corp. v. Brown*, 731 F.2d 1406, 1409 (9th Cir. 1984) (broad preemption to prevent conflicting and inconsistent state regulation); *American Progressive Life & Health Ins. Co. v. Corcoran*, 715 F.2d 784, 786 (2d Cir. 1983) (sweeping preemptive effect); *Hotel and Restaurant Employees and Bartenders Int'l Union Local 54 v. Danzinger*, 709 F.2d 815, 830 (3d Cir. 1983) (preemption as broad as "relate to" language), *vacated on other grounds*, 468 U.S. 491 (1984); *Stone and Webster Eng'g Corp. v. Ilsley*, 690 F.2d 323, 329 (2d Cir. 1982) (Section 1141(a) clearly eliminates the threat of conflicting or inconsistent state laws), *aff'd*, 463 U.S. 1220 (1983); *General Motors Corp. v. Buha*, 623 F.2d 455, 459 (6th Cir. 1980) (preemption central to ERISA).

Petitioners' claims "relate to" Mr. Kuhl's participation in an employee benefit plan and the administration of that plan by Lincoln National. Therefore, based upon the broad interpretation of 29 U.S.C. § 1144(a), petitioners' various state law claims are preempted because they all arise out of alleged conduct taken in connection with the administration of an employee benefit plan.

In *Pilot Life*, this Court unanimously held that ERISA preempts state tort law and contract actions for improper processing of benefit claims under an ERISA plan. 481 U.S. at 48. The Court ruled "the express provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.' " *Id.* at 46 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). In *Pilot Life*, the Court flatly held that "ERISA's civil enforcement remedies were intended to be exclusive." *Id.* at 54. Under *Pilot Life*, any "state lawsuit asserting improper processing of a claim of benefits under an ERISA-regulated plan . . . is preempted by § 514(a)." *Id.* at 57. For this reason, the preemption clause has an "unparalelled breadth." *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *aff'd*, 477 U.S. 901 (1986).

Petitioners argue Lincoln National's initial refusal to precertify benefits for the surgery was a "cancellation" of the scheduled surgery. However, petitioners cannot validly dispute that this action, however described, was taken in the context of Lincoln National's role as the administrator of an ERISA plan and because Barnes Hospital was not within the Belger Plan's "Service Area." As the district court stated throughout oral argument:

> It [Mr. Kuhl's surgery] was cancelled because the insurance company said it wasn't going to pay for it. And the hospital certainly isn't going to go ahead and do an operation if the insurance

> company is saying I'm not going to pay for it. Now, that's what insurance companies do all the time . . . as I wrote in the first opinion, I don't think it makes any difference, actually, how you characterize it. . . . Your view just doesn't make any sense to me because it isn't supported by any facts.

Regardless of how petitioners wish to characterize Lincoln National's action in connection with the precertification request, the action taken by Lincoln National was in connection with Lincoln National's interpretation of benefits afforded under the terms and conditions of the Belger Plan. As such, Lincoln National's actions and obligations are governed by ERISA and petitioners' state law claims are preempted.

B. The Eighth Circuit's Decision Does Not Conflict With Any Supreme Court Decision.

Contrary to petitioners' assertion, the Eighth Circuit's decision does not conflict with any Supreme Court decision. Petitioners' reliance upon *Mackey v. Lanier Collections Agency*, 486 U.S. 825 (1988) is simply misplaced. *Mackey* already has been held by this Court to be distinguishable from, and therefore consistent with, the other Supreme Court decisions relied upon by the Eighth Circuit.

In *Mackey*, this Court affirmed a Georgia Supreme Court decision that a state statute barring garnishment of ERISA welfare plan benefits was preempted, while the general state garnishment law was not preempted. This Court held the anti-garnishment statute's "express reference to ERISA plans" suffices to bring it within the federal law's preemptive reach. *Id.* at 830. With respect to the general garnishment statute, however, this Court relied

on ERISA provisions and the statute's structure to conclude Congress did not intend to forbid state garnishment procedures against welfare plans. *Id.* at 831.

In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), this Court held ERISA preempts a state common law claim of wrongful discharge to prevent attainment of ERISA pension benefits. The Court noted that although it had recognized certain limits to ERISA preemption, citing *Mackey* and *Ft. Halifax Packing Co. v. Coyne*,[7] these limitations were not applicable in the case before it:

> We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan. Nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension plan itself.

Ingersoll-Rand, 498 U.S. at 139. Here, as in *Ingersoll-Rand*, the existence of the Belger Plan not only is *a* critical factor, but the *only* reason Lincoln National had any dealings whatsoever with Mr. Kuhl. Because petitioners' alleged causes of action relate directly to the limitations, restrictions and exclusions of the Belger Plan, they are preempted by ERISA.

The Eighth Circuit explained why the limitation on preemption recognized in *Mackey* is not applicable in the present case:

> Under *Pilot Life*, any state law claim that Buddy Kuhl may have had against Lincoln National for

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[7] 482 U.S. 1, 23 (1987) (holding that a state law which required payment of severance benefits was not preempted because the statute did not require the establishment or maintenance of an ongoing plan).

> its conduct in delaying the surgery scheduled for July 6, 1989, arose from Lincoln National's denial of benefits under the Belger Plan. The Kuhls' attempt to invoke *Mackey* and to characterize their claims as merely tangentially related to the Plan is unpersuasive. Accordingly, the Kuhls' state law claims through Buddy Kuhl "relate to" the Belger Plan and are preempted by ERISA.

P.App. at A-12. As in *Ingersoll-Rand*, the Court's inquiry in this case necessarily is directed to the Belger Plan, because the action which forms the basis of the alleged causes of action "arose from Lincoln National's denial of benefits under the Belger Plan." P.App. A-12.

Petitioners rely on *dicta* in *Mackey* which lists "run of the mill" state law claims not preempted by ERISA, including claims against plans for unpaid rent, unpaid attorneys' fees, and libel. *See Mackey*, 486 U.S. at 833 n.8. Petitioners' characterization of the instant claim as within the "run of the mill tort claim" category simply is without support from the *Mackey* decision itself, or from the Eighth Circuit. None of these examples is analogous here because they are totally unrelated to the performance by the defendant plan of any ERISA functions. The Eighth Circuit referenced the *Mackey* list of "run of the mill" state claims, P.App. at A-12, but concluded the case was outside this category.

A cause of action for alleged medical negligence in connection with a benefit determination is neither a "run of the mill" state law claim, nor a "generally applicable" cause of action that "functions irrespective of the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139. Thus, the Eighth Circuit's conclusion that ERISA preempts such a cause of action does not conflict with *Mackey*, and there is no basis to claim that the decisions are in conflict with one another.

C. As In Corcoran, Certiorari Is Not Warranted Here.

This Court recently denied the petition for certiorari filed in a case with issues similar, if not identical, to those present here. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992). In *Corcoran*, plaintiff's obstetrician placed her in a category of high risk pregnancy and ordered that she be hospitalized so that he could monitor the fetus around the clock. In accordance with the plan, the doctor sought precertification from the administrator for the participant's hospital stay. The administrator solicited a second opinion on the participant's condition from another obstetrician who advised that "the company would be at considerable risk denying her doctor's recommendation." *Id.* at 1322. Despite both doctors' recommendations, the administrator determined that hospitalization was not necessary and refused to precertify the hospitalization, instead authorizing payment for 10 hours per day of home nursing care. Upon learning that precertification was denied, the participant left the hospital and returned home. *Id.* at 1324. Less than two weeks after returning home, during a time when no nurse was on duty, the fetus went into distress and died. *Id.*

Plaintiffs in *Corcoran* filed a wrongful death action in state court, alleging that their unborn child died as a result of various acts of negligence by the plan administrator and others. Defendant removed to federal court pursuant to ERISA, and thereafter moved for summary judgment. *Id.* As here, plaintiffs argued that the plan administrator ("United") made medical decisions, not benefit determinations. The Fifth Circuit rejected this theory:

> In our view, United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the Bell Plan. . . . When United's actions are viewed from this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination. The nature of the benefit determination is different than the type of decision that was at issue in *Pilot Life*, but it is a benefit determination nonetheless. The principle of *Pilot Life* that ERISA preempts state law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here.

Id. at 1324. Concluding that "the central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan," the Fifth Circuit affirmed the district court's grant of summary judgment against plaintiffs. *Id.* at 1334.

The same reasons why this Court denied the resulting petition for certiorari in *Corcoran* apply here. In this case, like *Corcoran*, petitioners seek to hold Lincoln National liable for actions taken in connection with its role as administrator of an ERISA plan. As in *Corcoran*, Lincoln National initially denied the participant's request for payment of benefits, and second opinions of physicians were reviewed in re-assessing the initial denial of benefit payments. Further, the policies in favor of applying ERISA's "unique preemptive force" are even stronger in this case. As opposed to the *Corcoran* plan administrator that did not necessarily rely upon an interpretation of the applicable ERISA plan when making its decisions, Lincoln National fully relied upon the restrictions and exclusions of the Belger Plan to determine whether the Plan provided benefits for a surgery to be performed by

non-participating doctors at a hospital outside the "Service Area." After concluding the Belger Plan did not provide benefits in such a situation, Lincoln National informed Barnes that it could not precertify the surgery.

Corcoran directly addresses, and rejects, petitioners' contention that Lincoln National provided "medical treatment" to Mr. Kuhl. Indeed, the *Corcoran* court ruled that medical decisions occur "in the context of making a determination about the availability of benefits under the plan," and therefore "relate to" an ERISA plan. *Id.* at 1311. Such a finding is further supported in this case, where petitioners allege Lincoln National provided "negligent medical treatment" to Mr. Kuhl without any evidence that Lincoln National provided any treatment to Mr. Kuhl at all.

If arguments such as those advanced by petitioners had any merit, this Court would have addressed them by granting certiorari in *Corcoran*, where essentially the same issues were presented for review. Just as *Corcoran* was consistent with prior Supreme Court precedent, thereby leaving no need for this Court to accept certiorari in that case, this case presents no novel legal issue warranting the grant of certiorari.

D. Federal Courts Consistently Rule That ERISA Preempts Wrongful Death Claims for Medical Malpractice.

Case law consistently establishes that ERISA preempts wrongful death claims. *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992); *Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733 (C.D. Cal. 1989); *Settles v. Golden Rule Ins. Co.*, 715 F. Supp. 1021 (D. Kan. 1989), *aff'd*, 927 F.2d 505 (10th Cir. 1991). Petitioners are unable to cite a single case from any

jurisdiction in which a wrongful death claim arising out of plan administration was not preempted by ERISA, nor can petitioners distinguish their wrongful death claim from those preempted by ERISA in every other case to have addressed the issue.

A wrongful death claim with facts strikingly similar to the present case also was dismissed due to ERISA preemption in *Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733 (C.D. Cal. 1989). In *Holmes*, the plan participant developed a liver disorder and made arrangements for surgery to be performed. The defendant insurance company erroneously affirmed that it provided coverage for the surgery. After arrangements for surgery had been made, the medical center called to verify that the insurer covered the cost of the surgery. This time the insurer answered that it did not. After a delay, the surgery was rescheduled. However, before another donor liver was available, the participant died. *Id.* at 734.

Plaintiffs filed a wrongful death action in California state court. Defendant removed to federal court and moved for summary judgment because ERISA preempted plaintiffs' state law claims, which were based entirely on representations made by the defendant acting in its capacity as the plan's administrator. *Id.*

The *Holmes* court reasoned that even if the state law in question is one of general application and is not designed to affect ERISA plans other than in an indirect manner, it is preempted if it is caught within ERISA's "expansive sweep." *Id.* at 736. The court also ruled that ERISA requires preemption of actions against plan administrators as well as plans themselves. *Id.* After granting defendant's petition for removal, the court dismissed all plaintiffs' causes of action.

In the present case, as in *Holmes*, a hospital which scheduled a surgery to be performed called the plan administrator to verify that benefits had been certified for surgery and was informed that the surgery was not a covered benefit under the plan. As in this case, the patient in *Holmes* died before the surgery could be rescheduled. Like Lincoln National, the defendant in *Holmes* made an assessment directly relating to benefits provided under an ERISA plan, and therefore the alleged causes of action are preempted by ERISA.

The Tenth Circuit Court of Appeals also ruled that a wrongful death cause of action was preempted by ERISA in *Settles v. Golden Rule Ins. Co.*, 715 F. Supp. 1021 (D. Kan. 1989), *aff'd*, 927 F.2d 505 (10th Cir. 1991). In *Settles*, after notification that his coverage was terminated by his ERISA plan administrator, plaintiff's husband allegedly suffered a heart attack and died as result of this notification. Plaintiff filed an action against her late husband's group health insurer, alleging causes of action (breach of contract, outrage, fraudulent denial of coverage, and wrongful death) similar to those alleged by petitioners in this case. The district court, relying upon ERISA preemption, granted defendant's motion to dismiss.

The Tenth Circuit ruled on appeal in *Settles* that ERISA preempted all plaintiff's claims:

> Here the injury alleged was a direct result of the termination of plan benefits and cannot be characterized as "wholly remote from the benefit plan" (citations omitted) . . . the factual basis for each of plaintiff's state law claims directly concerns the alleged improper administration of the benefit plan. Although plaintiff is not seeking benefits under the insurance policy, her claims

> require a finding that defendant wrongfully terminated Mr. Settles' insurance coverage. Therefore, the claims relate to the employee benefit plan.

Id. at 509.

Just as the *Settles* plaintiff claimed her husband's death was caused "as a direct consequence of defendant's action in terminating her husband's health insurance," *id.* at 507, petitioners claim Mr. Kuhl's death was caused as a direct result of Lincoln National's actions. In the present case, as in *Corcoran, Holmes* and *Settles,* the injuries alleged by petitioners are a direct result of supposed improper handling of Mr. Kuhl's claim for payment of benefits to cover his contemplated surgery. Petitioners have not cited a single case holding to the contrary and Lincoln National has not found any such case. Every applicable case leads to the conclusion that federal courts have resolved this issue identically each time it is raised, and there is no reason for the Court to grant certiorari here.

E. The Eighth Circuit's Decision Furthers The Purposes Behind ERISA's Preemption Provision.

In *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063 (1993), this Court recently expressed its reluctance to tamper with the delicate balance crafted by Congress when enacting ERISA:

> There is, in other words, a "tension between the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing pension costs." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981); *see also Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985); we will not attempt to adjust the balance between those competing goals that the text adopted by Congress has struck.

Id. at 2072. By seeking reversal of the lower courts, petitioners invite this Court not only to disrupt the statutory scheme adopted by Congress, but also to undercut substantial precedent interpreting ERISA since its enactment. Criticisms of ERISA's preemptive scope should be addressed to Congress and not this Court.

In enacting ERISA, Congress intended that "plans and plan sponsors would be subject to a uniform body of benefit law" and not subject to the "burdens of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). The Eighth Circuit's ruling furthers this purpose by avoiding a decision that could lead to the variant regulatory schemes Congress sought to avoid. State laws that subject plans to inconsistent regulations in different states, thereby increasing inefficiency and potentially causing the plan to respond by reducing benefit levels, consistently are preempted by ERISA. *See Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1333 (5th Cir.) *cert. denied*, 113 S. Ct. 812 (1992). As this Court stated in *Ingersoll-Rand*:

> It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

498 U.S. at 143. Similarly, there is a significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states. The cost of complying with varying substantive standards would increase the cost of providing utilization review services and ultimately would decrease the pool

of plan funds available to reimburse participants. *See Corcoran*, 965 F.2d at 1333.

A plan administrator that makes a commitment to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, monitoring the availability of funds for benefit payments, and other tasks. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide claims processing and benefit disbursement. However, such a system is difficult, if not impossible, to achieve if a plan administrator is subject to liability beyond what is set forth in ERISA.

Clearly, if plan administrators are subjected to state law claims, the resulting costs will be passed on to plans in the form of higher fees and lower benefits, all to the detriment of the vast majority of persons covered by the plans. With the national crisis facing this country in connection with health care and its costs, the balance struck by Congress in preempting claims such as those asserted by petitioners in this case ultimately benefits all plan participants. Subjecting a plan administrator to such uncertainty introduces inefficiencies and vulnerabilities that ultimately lead to reduced benefits in existing plans, and to certain plan administrators refraining from offering benefits at all. *Shaw*, 463 U.S. at 104.

Recognizing the threat of such uncertainty, Congress intended ERISA's preemptive scope to shield ERISA plan administrators from unforeseen liabilities. This is critical to the entire statutory scheme. H. R. Rep. No. 533, 93rd Cong. 1st Sess. 8, reprinted in 1974 U.S. Code Cong. & Admin. News 4639, 4646. Congress' comprehensive legislative scheme, including an integrated system of procedures for enforcement, is implicated in this case. It is

not for the courts to disturb the balance Congress determined appropriate. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

F. The Eighth Circuit Correctly Ruled That ERISA Preempts Petitioner Mary Kuhl's Emotional Distress Claim.

Petitioners attempt to rely on one circuit court case, *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir. 1988), *cert. denied*, 488 U.S. 909 (1988), which purportedly conflicts with decisions of other circuit courts as to whether emotional distress claims are preempted by ERISA. *Drinkwater* is distinguishable under the law and on its facts.

While *Drinkwater* did not preempt the emotional distress cause of action alleged in that case, the court nevertheless entered summary judgment because plaintiff neither alleged nor established that she suffered any injury to support her emotional distress claim. *Id.* at 826. Therefore, the language relied upon by petitioners in *Drinkwater* addressing ERISA is *dicta* at best.

Further, the failure of the *Drinkwater* court to recognize ERISA's preemption of claims for emotional distress places it directly at odds with virtually every other court which has addressed this issue. *See Powell v. Chesapeake and Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Johnson v. District 2 Marine Eng'rs Beneficial Assoc.*, 857 F.2d 514 (9th Cir. 1988).[8] In

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[8] *See also Meyer v. Employers Health Ins. Co.*, 722 F. Supp. 547 (E.D. Wis. 1989); *Rollo v. Maxicare of Louisiana, Inc.*, 698 F. Supp. 111 (E.D. La. 1988); *Pane v. RCA Corp.*, 667 F. Supp. 168 (D.N.J. 1987), *aff'd*, 868 F.2d 631 (3d Cir. 1989); *Smith v. Electronical Data Sys. Corp.*, 657 F. Supp. 1242 (D. Colo. 1987); *Folz v. Marriott Corp.*, 594 F. Supp. 1007 (W.D. Mo. 1984).

Powell, a case cited by both the Eighth Circuit and the district court, plaintiff brought a claim for intentional infliction of emotional distress against her former employer and her former benefit plan. The Fourth Circuit ruled that ERISA preempted plaintiff's claim:

> In this case, none of the state laws under which (plaintiff) claims relief have any intrinsic connection with employee benefit plans. The question is therefore whether state law claims which relate to the administration of an ERISA-governed plan, but which arise under general state laws, which themselves have no impact on employee benefit plans, are within the scope of ERISA preemption. Given the "unparalleled breadth of the preemption clause," *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), and the broad remedial policies of ERISA, we hold that state laws, insofar as they are invoked by beneficiaries claiming relief for injuries arising out of the administration of employee benefit plans, "relate to" such plans and, absent an applicable exemption, are preempted by ERISA.

Powell, 780 F.2d at 421. The application of ERISA's broad preemptive scope in *Powell* to claims against an HMO that are identical to those of petitioners' here provides additional support for the Eighth Circuit's ruling.

II. THE COURT OF APPEALS PROPERLY CONSIDERED THE EVIDENCE IN AFFIRMING THE DISTRICT COURT'S GRANT OF LINCOLN NATIONAL'S MOTION FOR SUMMARY JUDGMENT.

A. There Exists No Issue Of Material Fact.

In reviewing the district court's decision to grant summary judgment, the court of appeals properly considered

all evidence in the light most favorable to petitioners. Both the court of appeals and district court carefully reviewed both the factual and legal arguments raised by petitioners. These courts determined there was no genuine issue of any material fact and no merit to petitioners' legal position.

Petitioners' argument that these courts improperly reviewed the case from a factual standpoint fails to consider what facts actually are material to Lincoln National's motion for summary judgment. As set forth in *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986):

> The mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact. Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted.

Id. at 247-48 (emphasis in original). In this case, there is no dispute that petitioners' decedent, Buddy Kuhl, was a Belger employee, that Mr. Kuhl was a participant in the Belger Plan, that Lincoln National was the administrator of the Belger Plan, and that the Belger Plan is both an "employee benefit plan" and an "employee welfare benefit plan" within ERISA. Further, there is no dispute that Barnes Hospital was not within the "Service Area" for the Belger Plan, or that Lincoln National was not obligated under the Belger Plan to pay for services rendered outside the "Service Area" or for medical services rendered by doctors not participating in the Lincoln National network. More fundamentally, there is no dispute that whatever Lincoln National is alleged to have done, it took all actions in connection with its role in determining benefits under an ERISA plan. Therefore, although Lincoln

National takes issue with many of the factual characterizations made by petitioners, none of the facts material to ERISA's application have been disputed. The courts below correctly ruled that ERISA preempts petitioners' claims.

B. The District Court's Ruling Was Correct.

The district court set forth an exhaustive analysis of the applicable facts, law and the appropriate standard for summary judgment in its order. The district court was well aware of the burden imposed upon a party moving for summary judgment:

> In ruling on a motion for summary judgment, it is the court's obligation to view the facts in the light most favorable to the adverse party and to allow the adverse party the benefit of all reasonable inferences to be drawn from the evidence. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970); *Inland Oil and Trans. Co. v. United States*, 600 F.2d 725, 727-28 (8th Cir.), *cert. denied*, 444 U.S. 991 (1979). . . . A genuine issue of material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 106 S.Ct. 2505, 2510 (1986) . . . The inquiry to be made mirrors the standard for a directed verdict: whether the evidence presented by the party with the onus of proof is sufficient that a jury could properly proceed to return a verdict for that party. *Anderson v. Liberty Lobby* at 2511.

P.App. at C-7, 8.

Far from ignoring the appropriate summary judgment standard, the district court took great pains both to set forth the appropriate standard in its order, and to apply that standard to the facts of this case.

Additionally, six months after initially granting Lincoln National's motion for summary judgment, the district court entertained oral argument to further insure that petitioners' arguments had been thoroughly analyzed. During the oral argument, the district court again studied all factual and legal arguments raised by petitioners and again dismissed their claims. Thus, petitioners' contention that the district court erred in reviewing the evidence ignores the painstaking steps taken by the court to do exactly that.

C. The Eighth Circuit's Ruling Was Correct.

The court of appeals also applied the correct standard in reviewing the district court's grant of summary judgment. The court of appeals expressly recognized its obligation to view all inferences from the facts in the light most favorable to petitioners. Even doing so, however, the court of appeals ruled Lincoln National was entitled to summary judgment:

> Taking the facts in the light most favorable to the Kuhls, as we must for purposes of Lincoln National's motion for summary judgment, we are compelled to agree with the district court. .

P.App. at A-11.

Petitioners claim that the Eighth Circuit was disingenuous by "repeating the maxim" regarding the standard for summary judgment but then "flatly reject[ing] the facts averred by the Kuhls." Petitioners' Brief at 23. Not only does petitioners' argument improperly disparage the court of appeals, it also has no basis in law or fact. The lower court properly focused on those facts material to Lincoln National's motion for summary judgment, and correctly ruled there was no dispute as to any such fact. While petitioners make much of the testimony

of Dr. Levi, the Eighth Circuit correctly noted that there is no evidence that Mr. Kuhl sought medical treatment from Lincoln National at any time. Further, the court's review of the record made "clear that [Mr. Kuhl] was not under the misconception that Lincoln National had taken the place of his treating physicians. . . . " P.App. at A-12. This additional finding demonstrates that the court of appeals properly considered all evidence and correctly affirmed the judgment of the district court.

CONCLUSION

For the reasons stated herein, the Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit by Petitioners Mary Kuhl, Buddy Kuhl, Jr. and Marnie K. Kuhl should be denied.

Respectfully submitted,

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